

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

1800

Reg. Dist. No. 253

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>COUNTY <u>Princess Anne</u> MARYLAND  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Chesapeake</u> COUNTY <u>Princess Anne</u> |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Chesapeake</u>                              |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN                |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |   | STREET ADDRESS (If rural, give location)   |   |
| 3. NAME OF DECEASED (Type or Print)  | (First) <u>Wm</u> (Middle) <u>Cox</u> (Last) <u>Byler</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Feb</u> <u>2</u> <u>1951</u>                     |   |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u>                          | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH<br><u>May 26, 1877</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired factory worker</u> |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Congoleum plant</u>                                  | 9. AGE last birthday<br><u>73</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min. |
| 13. FATHER'S NAME<br><u>Don't know</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Don't know</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>unknown</u>   |   | 16. SOCIAL SECURITY No.<br><u>185-03-1456</u>  |   |
| 17. INFORMANT AND ADDRESS<br><u>Barton Bros - Chesapeake Md</u>  |   |  |   |

**18. MEDICAL CERTIFICATION**

|  |  |                                  |
|--|--|----------------------------------|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) <u>Exposure - froze to death:</u><br>Antecedent cause(s) (b) <u>He had been on a drunk for a week - he left a frost room for house at 10 P.M. - fell in a mud puddle &amp; weather</u><br>(c) <u>Changed very cold - he froze &amp; was found dead at 7 a.m.</u> |  |                                  |

|   |  |
|---|--|
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION   |
| 21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                    | PLACE (Home, farm, factory, street, office bldg., etc.) INJURY   |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2</u> <u>2</u> <u>51</u> m.   | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |
| HOW DID INJURY OCCUR?<br><u>Exposure</u>  |  |

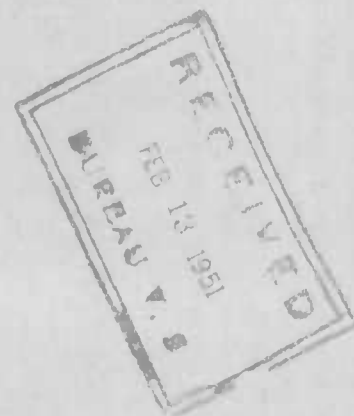
|   |  |
|---|--|
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> . |  |
| SIGNATURE<br><u>W. Henry Fisher M.D.</u><br><u>Deputy Med. Exam for 2 a. Co. Md.</u>  | DATE SIGNED<br><u>2/4/51</u>   |
| 23. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | DATE THEREOF<br><u>July 4-51</u>                                       |
| NAME OF CEMETERY OR CREMATORY<br><u>Chesapeake</u>  | LOCATION (City, town, or county) (State)<br><u>Chesapeake Maryland</u> |
| DATE REC'D BY LOCAL REG.<br><u>2/4/51</u>   | 24. FUNERAL DIRECTOR<br><u>Barton Bros Chesapeake Md</u>               |

690VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1801

|  |                                  |  |                                       |
|--|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH-<br>COUNTY <u>Queen Anne</u> MARYLAND                                      |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>     |                                       |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Barclay</u> |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Barclay</u> |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>no</u>                                       |                                  | STREET ADDRESS<br>(If rural, give location)  |                                       |
| 3. NAME OF DECEASED<br>(Type or Print) <u>James Herman Clow</u>                              |                                  | 4. DATE OF DEATH<br>(Month) <u>2</u> (Day) <u>13</u> (Year) <u>1951</u>                      |                                       |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>                            | 8. DATE OF BIRTH<br><u>10/20/1867</u> |
| 9. AGE last birthday<br><u>83</u> yrs.   |                                  | 10. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                 |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                 |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                                       |
| 13. FATHER'S NAME<br><u>John E. Clow</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Ellen Everett</u>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>               |                                  | 16. SOCIAL SECURITY No.<br><u>no</u>   |                                       |
| 17. INFORMANT AND ADDRESS<br><u>Emily Clow, Barclay, Md.</u>                                 |                                  |  |                                       |

|   |  |  |
|---|--|--|
| 18. MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |  |
| (a) Immediate cause<br><u>Acute Cardiac Dilatation</u>  |  |  |
| (b) Antecedent cause(s)<br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last<br><u>Chronic myocarditis</u> |  |  |
| (c) <u>ArterioSclerosis</u>   |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>Senility</u>    |  |  |
| 19a. DATE OF OPERATION<br><u>no</u>   | 19b. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE<br><u>no</u>  | PLACE (Home, farm, factory, street, office bldg., etc.)<br><u>INJURY</u>                             | (CITY OR TOWN) (COUNTY) (STATE)  |
| TIME (Month) (Day) (Year) (Hour)<br>OF INJURY   | INJURY OCCURRED<br>While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR?  |

22. I hereby certify that I attended the deceased from Jan. 2, 1951, to Feb. 13, 1951, that I last saw the deceased alive on Feb. 11, 1951, and that death occurred at 6 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

|  |   |  |  |         |
|--|---|--|--|---------|
| 23. BURIAL, CREMATION REMOVAL (Specify)<br><u>Burial</u> | DATE THEREOF<br><u>2/17/51</u>                | NAME OF CEMETERY OR CREMATORY<br><u>Sudlersville</u>           | LOCATION (City, town, or county)<br><u>Sudlersville, Md.</u> | (State) |
| DATE REC'D BY LOCAL REG.<br><u>2/15/51</u>               | REGISTRAR'S SIGNATURE<br><u>Edgar L. Lane</u> | 24. FUNERAL DIRECTOR<br><u>Edgar L. Lane, Church Hill, Md.</u> | ADDRESS  |         |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

290116

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 253

|   |                               |   |   |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH-<br>COUNTY <u>Queene Anne</u> MARYLAND  |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Maryland</u> COUNTY <u>Queene Anne</u> |   |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>                            |                               | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>      |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                               | STREET ADDRESS (If rural, give location)  |   |
| 3. NAME OF DECEASED (Type or Print)   | (First) <u>Mary</u>           | (Middle) <u>L.</u>  | (Last) <u>Jones</u>   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>                           | 8. DATE OF BIRTH <u>June 30, 1886</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>    |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>   | 9. AGE last birthday <u>84</u> yrs. <u>18</u> Months <u>53</u> Days <u>19</u> Hours <u>53</u> Mins. |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   |
| 13. FATHER'S NAME <u>John R. Jones</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Sarah Higgins</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u> |                               | 16. SOCIAL SECURITY NO. <u>Mrs. John Collier--Cambridge, Md.</u>                          |   |
| 17. INFORMANT AND ADDRESS   |                               |   |   |

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

447x Immediate cause

92d Antecedent cause(s)  
Disease or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(a) Enlarged Heart valvular incompet-  
(b) Hypertension - arterio sclerosis  
(c)

INTERVAL BETWEEN ONSET AND DEATH

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 13, 1951, to July 17, 1951, that I last saw the deceased

alive on July 18, 1951, and that death occurred at 12 m., from the causes and on the date stated above.

SIGNATURE Dr. Charles E. Miller ADDRESS Stonemiller Rd DATE SIGNED 7/20/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREON Feb. 21 NAME OF CEMETERY OR CREMATORY Kingsley Church LOCATION (City, town, or county) Chester, Maryland (State)

DATE REC'D BY LOCAL REG. Feb 21, 1951 REGISTRAR'S SIGNATURE Elizabeth Hoster 24. FUNERAL DIRECTOR Edgar L. Lane ADDRESS Church Hill, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## 1893

MARGIN RESERVED FOR BINDING

|  |                         |   |   |
|--|-------------------------|---|---|
| <b>1. PLACE OF DEATH- COUNTY</b>   |                         | <b>2. USUAL RESIDENCE (HOME) OF DECEASED- STATE</b>                   |   |
| Queene Anne MARYLAND   |                         | Maryland QUEENE ANNE  |   |
| CITY (If outside corporate limits, write RURAL and OR give nearest town)   | TOWN                    | CITY (If outside corporate limits, write RURAL and give nearest town) | TOWN                                    |
| Sudlersville   |                         | Sudlersville  |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                         | STREET ADDRESS (If rural, give location)                              |   |
|  |                         |   |   |
| <b>3. NAME OF DECEASED (Type or Print)</b>   | (First)                 | (Middle)  | (Last)                                  |
| William  | H.                      | Jones   |   |
| <b>5. SEX</b>  | <b>6. COLOR OR RACE</b> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>               | <b>8. DATE OF BIRTH</b>                 |
| Male   | White                   | Married   | July 17, 1864                           |
|  |                         | <b>9. AGE last birthday</b>   | <b>10. KIND OF BUSINESS OR INDUSTRY</b> |
|  |                         | 86 yrs.   | Rail-Road                               |
| <b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>   |                         | <b>11. BIRTHPLACE (State or foreign country)</b>                      |   |
| Section-Gang   |                         | Maryland  |   |
| <b>13. FATHER'S NAME</b>   |                         | <b>14. MOTHER'S MAIDEN NAME</b>                                       |   |
| William Jones  |                         | Unknown   |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)</b>  |                         | <b>16. SOCIAL SECURITY NO.</b>  |   |
|  |                         |   |   |
| <b>17. INFORMANT AND ADDRESS</b>   |                         |   |   |
| Ralph Jones--Dover, Del.   |                         |   |   |
| <b>18. MEDICAL CERTIFICATION</b>   |                         |   |   |
| <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                         |   |   |
| (a) Immediate cause  |                         |   |   |
| Acute Cardiac Dilatation   |                         |   |   |
| (b) Antecedent cause(s)<br>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last  |                         |   |   |
| Chronic myocardial Arteriosclerosis<br>Lung Emphysema  |                         |   |   |
| (c) Other significant conditions<br>Conditions contributing to the death but not related to the disease or condition causing death.  |                         |   |   |
| Exacerbations of none  |                         |   |   |
| <b>19a. DATE OF OPERATION</b>  |                         | <b>19b. MAJOR FINDINGS OF OPERATION</b>                               |   |
| NO   |                         |   |   |
| <b>21. ACCIDENT SUICIDE HOMICIDE</b>   |                         | <b>20. AUTOPSY?</b>   |   |
| (Specify)  |                         | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| NO   |                         |   |   |
| <b>PLACE (Home, farm, factory, street, OF office bldg., etc.)</b>  |                         | <b>(CITY OR TOWN)</b>   |   |
| INJURY   |                         |   |   |
| <b>TIME (Month) (Day) (Year) (Hour) OF INJURY</b>  |                         | <b>HOW DID INJURY OCCUR?</b>  |   |
|  |                         |   |   |
| <b>22. I hereby certify that I attended the deceased from Dec 4, 1957, to Feb 15, 1957, that I last saw the deceased alive on Feb 14, 1957, and that death occurred at 3 A.M., from the causes and on the date stated above.</b> |                         |   |   |
| <b>SIGNATURE</b>   |                         | <b>DATE SIGNED</b>  |   |
| Q. M. Sullivan   |                         | 2/21/57   |   |
| <b>BURIAL, CREMATION REMOVAL (Specify)</b>   |                         | <b>NAME OF CEMETERY OR CREMATORY</b>                                  |   |
| Burial   |                         | Sudlersville  |   |
| <b>DATE THEREOF</b>  |                         | <b>LOCATION (City, town, or county)</b>                               |   |
| Feb. 23  |                         | Sudlersville, Md.   |   |
| <b>DATE REC'D BY LOCAL REG.</b>  |                         | <b>REGISTRAR'S SIGNATURE</b>  |   |
| Feb. 21  |                         | Edgar L. Lane   |   |
| <b>FUNERAL DIRECTOR</b>  |                         | <b>ADDRESS</b>  |   |
| Edgar L. Lane  |                         | Church Hill, Md.  |   |

970506





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH-<br>COUNTY <u>Queene Anne</u> MARYLAND  |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Maryland</u> COUNTY <u>Queene Anne</u>  |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Price</u>                    |                               | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Price</u> |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                               | STREET ADDRESS (If rural, give location)   |   |
| 3. NAME OF DECEASED (First) <u>Stephen</u> (Middle) <u>C.</u> (Last) <u>Kimble</u>                            |                               | 4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>17</u> (Year) <u>1951</u>                    |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>                            | 8. DATE OF BIRTH <u>Dec. 20, 1869</u> 9. AGE last birthday <u>81</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm-Owner</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>                 |
| 13. FATHER'S NAME <u>Stephen Kimble</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Rebecca Sparks</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)      |                               | 16. SOCIAL SECURITY NO.  |   |
|   |                               | 17. INFORMANT AND ADDRESS <u>Mrs. Howard Stant--Price, Md.</u>                             |   |

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331x Immediate cause

(a) Cerebral HemorrhageINTERVAL BETWEEN ONSET AND DEATH  
4 days

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION                     |  | 19b. MAJOR FINDINGS OF OPERATION  |  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE    |  | PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY                                 |  | (CITY OR TOWN) (COUNTY) (STATE)                                       |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY |  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> |  | HOW DID INJURY OCCUR?   |  |

22. I hereby certify that I attended the deceased from Feb 13, 1951, to Feb 17, 1951, that I last saw the deceased alive on Feb 16, 1951, and that death occurred at 5:10 P m., from the causes and on the date stated above.

SIGNATURE

W. Henry Fisher M.D.

(Degree or title)

ADDRESS

Centerville Md

DATE SIGNED

2/20-51

|   |  |  |  |   |         |
|---|--|--|--|---|---------|
| 23. BURIAL, CREMATION REMAINS (Specify) <u>Buried</u> |  | DATE THEREOF <u>Feb. 21</u>                | NAME OF CEMETERY OR CREMATORY <u>Church Hill</u> | LOCATION (City, town, or county) <u>Church Hill, Md.</u>                  | (State) |
| DATE REC'D BY LOCAL REG. <u>Feb. 20</u>               |  | REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u> |  | 24. FUNERAL DIRECTOR <u>Edgar L. Lane</u> ADDRESS <u>Church Hill, Md.</u> |         |

290116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
FEB 28 1951  
H. H. HAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 254

|   |                                 |   |                                      |
|---|---------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>COUNTY <u>QUEEN ANNE</u> MARYLAND  |                                 | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNE</u>                                 |                                      |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>GREENVILLE</u>   |                                 | CITY (If outside corporate limits, write RURAL and give nearest town) <u>GREENVILLE</u>                                 |                                      |
| TOWN <u>GREENVILLE</u>  |                                 | TOWN <u>GREENVILLE</u>  |                                      |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                                 | STREET ADDRESS (If rural, give location)  |                                      |
| 3. NAME OF DECEASED<br>(Type or Print) <u>THOMAS</u> (First) <u>LOVE</u> (Last)   |                                 | 4. DATE OF DEATH <u>FEB 3</u> 19 <u>51</u> (Month) (Day) (Year)   |                                      |
| 5. SEX <u>MALE</u>  | 6. COLOR OR RACE <u>COLORED</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWER</u>   | 8. DATE OF BIRTH <u>1877</u> 74 yrs. |
| 9. AGE last birthday <u>74</u> yrs.   |                                 | 10. AGE last birthday <u>74</u> yrs.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WORK</u>   |                                      |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>   |                                 | 12. CITIZEN OF WHAT COUNTRY <u>USA.</u>   |                                      |
| 13. FATHER'S NAME <u>UNKNOWN</u>  |                                 | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>  |                                 | 16. SOCIAL SECURITY No. <u>NONE</u>   |                                      |
| 17. INFORMANT AND ADDRESS <u>FLORENCE WHITFIELD, GREENVILLE, MD</u>   |                                 | 18. MEDICAL CERTIFICATION   |                                      |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |                                 | INTERVAL BETWEEN ONSET AND DEATH  |                                      |
| Immediate cause (a) <u>Coronary occlusion</u>   |                                 | <u>Febr. 3, 1951</u>  |                                      |
| Antecedent cause(s) (b) <u>Sclerosis coronary arteries, myocardial degeneration Arteriosclerosis (general)</u>  |                                 | <u>Several years</u>  |                                      |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Nephro-sclerosis</u>  |                                 | <u>Years</u>  |                                      |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |                                 |   |                                      |
| 19a. DATE OF OPERATION  |                                 | 19b. MAJOR FINDINGS OF OPERATION  |                                      |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |                                 |   |                                      |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)   |                                 | PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)                              |                                      |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |                                 | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR? |                                      |
| 22. I hereby certify that I attended the deceased from <u>Febr. 3</u> , 19 <u>51</u> , to <u>Febr. 3</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Febr. 3</u> , 19 <u>51</u> , and that death occurred at <u>11 P.</u> m., from the causes and on the date stated above. |                                 |   |                                      |
| SIGNATURE <u>Theodor Sattelmaier, M.D.</u>  |                                 | ADDRESS <u>Stevensville</u> DATE SIGNED <u>Febr. 5, 1951</u>  |                                      |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>   |                                 | DATE THEREOF <u>2-7-51</u>  |                                      |
| NAME OF CEMETERY OR CREMATORY <u>DRYANES</u>  |                                 | LOCATION (City, town, or county) <u>GREENVILLE, MARYLAND</u>  |                                      |
| DATE REC'D BY LOCAL REG. <u>2-7-51</u>  |                                 | REGISTRAR'S SIGNATURE <u>Helen M. Aldridge</u>  |                                      |
| 24. FUNERAL DIRECTOR <u>Town D. Williams</u>  |                                 | ADDRESS <u>Easton, Md.</u>  |                                      |

MARGIN RESERVED FOR BINDING

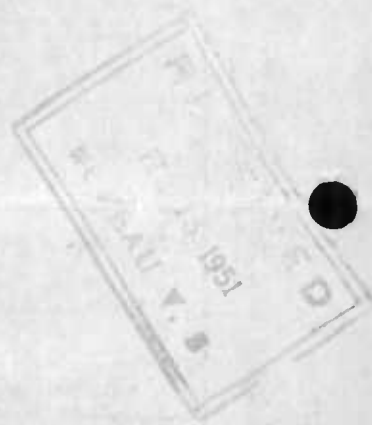
VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED - U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE

U.S. DEPARTMENT OF JUSTICE



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH-<br>COUNTY <u>Queene Anne</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Maryland</u> COUNTY <u>Queene Anne</u>         |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Sudlersville</u>              |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Sudlersville</u> |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                                  | STREET ADDRESS (If rural, give location)  |  |
| 3. NAME OF DECEASED<br>(Type or Print)   | (First) <u>John</u>              | (Middle) <u>Wesley</u>  | (Last) <u>McKnett</u>  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>Widowed</u>                                | 8. DATE OF BIRTH<br><u>Jan. 22, 1867</u>                     |
| 9. AGE last birthday<br><u>84</u> yrs.   |                                  | 4. DATE OF DEATH<br><u>Feb. 15</u>  | (Year)<br><u>1951</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Salesman</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Fertilizer</u>  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u> |
| 13. FATHER'S NAME<br><u>Unknown</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)       |                                  | 17. INFORMANT AND ADDRESS<br><u>Leonard McKnett Easton, Md.</u>                                   |  |
| 16. SOCIAL SECURITY NO.  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause

(a) Cardiac Decompensation

93d

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic myocardiopathy(c) Pericarditis

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 14, 1950, to Feb. 15, 1951, that I last saw the deceasedalive on Feb. 14, 1951, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 18Edgar L. LaneEdgar L. LaneChurch Hill, Md.

490626

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

1807

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH - COUNTY <u>Queen Anne's</u> MARYLAND  |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u> |  |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>                           |                               | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                               | STREET ADDRESS (If rural, give location)   |  |
| 3. NAME OF DECEASED (First) <u>EUDORA</u> (Middle) <u>STEVENS</u> (Last) <u>MORRIS</u>                             |                               | 4. DATE OF DEATH (Month) <u>July</u> (Day) <u>24</u> (Year) <u>1957</u>                  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>                           | 8. DATE OF BIRTH <u>Oct 5 - 1867</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>         |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>                                       | 9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hr. Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>   |                               | 12. CITIZEN OF WHAT COUNTRY <u>USA</u>   |  |
| 13. FATHER'S NAME <u>Rev. C. K. Morris</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Martha Higgins</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) |                               | 16. SOCIAL SECURITY NO. <u>None</u>  |  |
| 17. INFORMANT AND ADDRESS <u>James E. Bostie</u>   |                               | <u>Nicholas, Md</u>  |  |

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

#### Immediate cause

(a) Chronic myocarditis

#### Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

#### 20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1 - 1957, to Feb 24 - 1957, that I last saw the deceased

alive on Feb 24 - 1957, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. Henry Fisher M.D.

Centerville Md.

2/26/57

#### 23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2-26-57

Glenn Armstrong

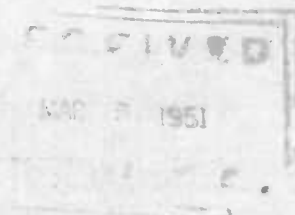
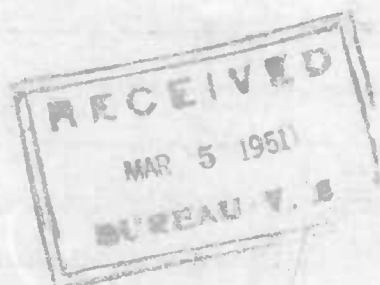
Barton Ben. Centerville Md.

512459

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

1808

Reg. Dist. No. 252

|   |                               |  |                                   |
|---|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH-<br>COUNTY <u>Queen Anne</u> MARYLAND   |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Maryland</u> COUNTY <u>Queen Anne</u> |                                   |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>                      |                               | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u> |                                   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>   |                               | STREET ADDRESS (If rural, give location) <u>Tilgham Ave.</u>                             |                                   |
| 3. NAME OF DECEASED (Type or Print)   | (First) <u>George</u>         | (Middle) <u>L.</u>   | (Last) <u>Mullikin</u>            |
| 4. DATE OF DEATH  | (Month) <u>2</u>              | (Day) <u>13</u>  | (Year) <u>50</u>                  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>                          | 8. DATE OF BIRTH <u>6/26/1892</u> |
| 9. AGE last birthday <u>58</u> yrs.   |                               | 10. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>  |                                   |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |                                   |
| 13. FATHER'S NAME <u>George Mullikin</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Margaret Wilkerson</u>                                       |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>                                   |                               | 16. SOCIAL SECURITY NO. <u>None</u>  |                                   |
| 17. INFORMANT AND ADDRESS <u>Mrs. Grace Mullikin Centerville, Md.</u>   |                               |  |                                   |

|  |   |   |
|--|---|---|
| 18. MEDICAL CERTIFICATION  |   | INTERVAL BETWEEN ONSET AND DEATH                                      |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |   |   |
| (a) Immediate cause <u>General Paralysis</u>   |   | <u>94</u>   |
| (b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last              |   |   |
| (c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. |   |   |
| 19a. DATE OF OPERATION   | 19b. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)  | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY                                 | (CITY OR TOWN) (COUNTY) (STATE)                                       |
| TIME (Month) (Day) (Year) (Hour) OF INJURY   | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from Feb 1, 1942, to Feb 13, 1951, that I last saw the deceased alive on Feb 12, 1951, and that death occurred at 1:15 A. m., from the causes and on the date stated above.

SIGNATURE W. Henry Fisher M.D. ADDRESS Centerville Md DATE SIGNED 2/14-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 2/15/51 NAME OF CEMETERY OR CREMATORY Centerville LOCATION (City, town, or county) (State) Centerville, Md.

DATE REC'D BY LOCAL REG. 2-14-51 REGISTRAR'S SIGNATURE Glenn Armstrong 24. FUNERAL DIRECTOR ADDRESS R.B. Rawlings Greensboro, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

290116

# MARYLAND STATE DEPARTMENT OF HEALTH

201 N. Calvert Street, Baltimore

## CERTIFICATE OF DEATH

By the State

|  |  |   |  |
|--|--|---|--|
| 1. Name of deceased (Print or Type)      |  | 2. Sex                                    |  |
| 3. Date of birth (Month, Day, Year)      |  | 4. Age                                    |  |
| 5. Place of birth (City, State, Country) |  | 6. Usual residence (City, State, Country) |  |
| 7. Cause of death (Immediate)            |  | 8. Cause of death (Underlying)            |  |
| 9. Date of death (Month, Day, Year)      |  | 10. Time of death (Hour, Minute)          |  |
| 11. Signature of attending physician     |  | 12. Signature of medical examiner         |  |
| 13. Signature of registrar               |  | 14. Signature of informant                |  |

|   |  |                                       |  |
|---|--|---------------------------------------|--|
| 15. Name of informant (Print or Type)           |  | 16. Relationship to deceased          |  |
| 17. Address of informant (City, State, Country) |  | 18. Date of completion of certificate |  |
| 19. Signature of informant                      |  | 20. Signature of registrar            |  |
| 21. Signature of medical examiner               |  | 22. Signature of attending physician  |  |
| 23. Signature of registrar                      |  | 24. Signature of informant            |  |
| 25. Signature of medical examiner               |  | 26. Signature of attending physician  |  |
| 27. Signature of registrar                      |  | 28. Signature of informant            |  |
| 29. Signature of medical examiner               |  | 30. Signature of attending physician  |  |
| 31. Signature of registrar                      |  | 32. Signature of informant            |  |
| 33. Signature of medical examiner               |  | 34. Signature of attending physician  |  |
| 35. Signature of registrar                      |  | 36. Signature of informant            |  |
| 37. Signature of medical examiner               |  | 38. Signature of attending physician  |  |
| 39. Signature of registrar                      |  | 40. Signature of informant            |  |
| 41. Signature of medical examiner               |  | 42. Signature of attending physician  |  |
| 43. Signature of registrar                      |  | 44. Signature of informant            |  |
| 45. Signature of medical examiner               |  | 46. Signature of attending physician  |  |
| 47. Signature of registrar                      |  | 48. Signature of informant            |  |
| 49. Signature of medical examiner               |  | 50. Signature of attending physician  |  |
| 51. Signature of registrar                      |  | 52. Signature of informant            |  |
| 53. Signature of medical examiner               |  | 54. Signature of attending physician  |  |
| 55. Signature of registrar                      |  | 56. Signature of informant            |  |
| 57. Signature of medical examiner               |  | 58. Signature of attending physician  |  |
| 59. Signature of registrar                      |  | 60. Signature of informant            |  |
| 61. Signature of medical examiner               |  | 62. Signature of attending physician  |  |
| 63. Signature of registrar                      |  | 64. Signature of informant            |  |
| 65. Signature of medical examiner               |  | 66. Signature of attending physician  |  |
| 67. Signature of registrar                      |  | 68. Signature of informant            |  |
| 69. Signature of medical examiner               |  | 70. Signature of attending physician  |  |
| 71. Signature of registrar                      |  | 72. Signature of informant            |  |
| 73. Signature of medical examiner               |  | 74. Signature of attending physician  |  |
| 75. Signature of registrar                      |  | 76. Signature of informant            |  |
| 77. Signature of medical examiner               |  | 78. Signature of attending physician  |  |
| 79. Signature of registrar                      |  | 80. Signature of informant            |  |
| 81. Signature of medical examiner               |  | 82. Signature of attending physician  |  |
| 83. Signature of registrar                      |  | 84. Signature of informant            |  |
| 85. Signature of medical examiner               |  | 86. Signature of attending physician  |  |
| 87. Signature of registrar                      |  | 88. Signature of informant            |  |
| 89. Signature of medical examiner               |  | 90. Signature of attending physician  |  |
| 91. Signature of registrar                      |  | 92. Signature of informant            |  |
| 93. Signature of medical examiner               |  | 94. Signature of attending physician  |  |
| 95. Signature of registrar                      |  | 96. Signature of informant            |  |
| 97. Signature of medical examiner               |  | 98. Signature of attending physician  |  |
| 99. Signature of registrar                      |  | 100. Signature of informant           |  |

RECEIVED  
FEB 19 1951  
READ

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

1899 251  
Reg. Dist. No.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH-<br>COUNTY <u>Queene Anne</u> MARYLAND   |   | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>Maryland</u> COUNTY <u>Queene Anne</u> |   |
| CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Barclay</u>                  |   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>      |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |   | STREET ADDRESS (If rural, give location)  |   |
| 3. NAME OF DECEASED (Type or Print)  | (First) <u>Albert</u>   | (Middle) <u>Louis</u>   | (Last) <u>Myers</u>                           |
| 4. DATE OF DEATH   | (Month) <u>Feb.</u>   | (Day) <u>19</u>   | (Year) <u>51</u>                              |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>Colored</u>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>                           | 8. DATE OF BIRTH <u>March, 1873</u>           |
| 9. AGE last birthday <u>77</u> yrs.  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm-Laborer</u> |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   |
| 13. FATHER'S NAME <u>Unknown</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) |   | 16. SOCIAL SECURITY No.   |   |
| 17. INFORMANT AND ADDRESS <u>Welfare Board Records-Centreville,</u>                                      |   |   |   |

|   |   |   |
|---|---|---|
| 18. MEDICAL CERTIFICATION   |   | INTERVAL BETWEEN ONSET AND DEATH <u>37 hrs</u>                        |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |   |   |
| 410 x Immediate cause (a) <u>Myocardial Infarction</u>  |   |   |
| 92 b Antecedent cause(s) (b) <u>Rheumatism</u>  |   |   |
| Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Heart</u>  |   |   |
| II. OTHER SIGNIFICANT CONDITIONS  |   |   |
| Conditions contributing to the death but not related to the disease or condition causing death. <u>Rheumatism</u> |   |   |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT (Specify) <u>SUICIDE HOMICIDE</u>  | PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>                          | (CITY OR TOWN) (COUNTY) (STATE)                                       |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR?   |

22. I hereby certify that I attended the deceased from Feb 15, 1951, to Feb 19, 1951, that I last saw the deceased alive on Feb 19, 1951, and that death occurred at 10:15 m., from the causes and on the date stated above.

SIGNATURE Edgar L. Lane (Degree or title) ADDRESS Church Hill, Md. DATE SIGNED Feb 20/1951

|   |  |  |   |
|---|--|--|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | DATE THEREOF <u>Feb. 24</u>                | NAME OF CEMETERY OR CREMATORY <u>Barclay Colored</u> | LOCATION (City, town, or county) (State) <u>Barclay, Maryland</u> |
| DATE REC'D BY LOCAL REG. <u>Feb. 23</u>               | REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u> | 24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>            | ADDRESS <u>Church Hill, Md.</u>                                   |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1810 254

|   |                                 |   |  |
|---|---------------------------------|---|--|
| 1. PLACE OF DEATH:<br>COUNTY <u>QUEEN ANNE</u> MARYLAND<br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - QUEENSTOWN</u><br>TOWN <u>QUEENSTOWN</u><br>HOSPITAL OR INSTITUTION OR STREET ADDRESS |                                 | 2. USUAL RESIDENCE (HOME) OF DECEASED:<br>STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNE</u><br>CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - QUEENSTOWN</u><br>TOWN <u>QUEENSTOWN</u><br>STREET ADDRESS (If rural, give location) |  |
| 3. NAME OF DECEASED<br>(Type or Print) <u>BELL</u> (First) (Middle) (Last) <u>NICKERSON</u>   |                                 | 4. DATE OF DEATH <u>FEB. 16</u> 19 <u>51</u><br>(Month) (Day) (Year)  |  |
| 5. SEX <u>FEMALE</u>  | 6. COLOR OR RACE <u>COLORED</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>   | 8. DATE OF BIRTH <u>MAY 10 - 1900</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>  | 9. AGE last birthday <u>50</u> yrs. <u>11</u> months <u>17</u> days <u>22</u> hours <u>51</u> min. |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>   |                                 | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13. FATHER'S NAME <u>BAS 3 ROBERTO</u>  |                                 | 14. MOTHER'S MAIDEN NAME <u>Martha Roberto</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>  |                                 | 16. SOCIAL SECURITY NO. <u>213-22-8741</u>  |  |
| 17. INFORMANT <u>JAMES NICKERSON</u>  |                                 |   |  |

|  |  |                                  |
|--|--|----------------------------------|
| 18. MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN DEATH AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |  | <u>Febr. 15, 51.</u>             |
| Immediate cause (a) <u>cerebral hemorrhage</u>   |  |                                  |
| Antecedent cause(s) (b) <u>Arterio sclerosis (general)</u>   |  |                                  |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) |  |                                  |

|   |  |
|---|--|
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION   |
| 21. ACCIDENT (Specify) <u>HOMICIDE</u>  | PLACE (Home, farm, factory, street, OF <u>INJURY</u> (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>  | INJURY OCCURRED While at <u>Work</u> Not While <u>At work</u> HOW DID INJURY OCCUR?  |

|   |   |
|---|---|
| 22. I hereby certify that I attended the deceased from <u>Febr. 15, 1951.</u> to <u>Febr. 16, 1951.</u> ; that I last saw the deceased alive on <u>Febr. 15, 1951.</u> , and that death occurred at <u>12:30 a.m.</u> , from the causes and on the date stated above. |   |
| SIGNATURE <u>Theodor Jettelmair M.D.</u> (Degree or title)  | DATE SIGNED <u>Febr. 16, 1951.</u>            |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>   | DATE THEREOF <u>FEB. 19, 51</u>               |
| NAME OF CEMETERY OR CREMATORY <u>St. Ann's Catholic Cemetery, Easton, Md.</u>   | LOCATION (City, town, or county) (State)      |
| DATE REC'D BY LOCAL REG. <u>Feb. 18 '51</u>   | REGISTRAR'S SIGNATURE <u>John M. Dedridge</u> |
| 24. FUNERAL DIRECTOR <u>John D. Williams</u>  | ADDRESS <u>EASTON, MD.</u>                    |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 21 1951  
BUREAU V. B

## MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

 1811  
 Reg. Dist. No. 254

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH-<br>COUNTY <u>Queen Anne</u> MARYLAND   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED-<br>STATE <u>MD</u> COUNTY <u>Queen Anne</u>                    |  |
| CITY (If outside corporate limits, write RURAL and OR give nearest town)<br>TOWN <u>Groeswille R.F.D.</u>   |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Groeswille MD</u> |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>None</u>  |  | STREET ADDRESS<br><u>Narrows</u>  |  |
| 3. NAME OF DECEASED<br>(Type or Print)  |  | 4. DATE OF DEATH  |  |
| (First) <u>Refrad</u> (Middle) <u>S.</u> (Last) <u>Perry</u>  |  | (Month) <u>Feb</u> (Day) <u>2</u> (Year) <u>1951</u>  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED.<br>(Specify)   | 8. DATE OF BIRTH                           |
|   |  |   | <u>Nov 1-1876</u>                          |
| 9. AGE last birthday<br><u>74</u> yrs.  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u> | 11. BIRTHPLACE (State or foreign country)<br><u>Fairfield Conn</u>                                    | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |
| 13. FATHER'S NAME<br><u>Burr Perry</u>  | 14. MOTHER'S MAIDEN NAME<br><u>Kate Emily Peet</u>   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>                        |  |
| 16. SOCIAL SECURITY No.<br><u>None</u>  |  | 17. INFORMANT AND ADDRESS<br><u>Mrs J. L. Jewee 878 Brown Rd</u>                                      |  |
| 18. MEDICAL CERTIFICATION   |  |   |  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |  |   | INTERVAL BETWEEN ONSET AND DEATH           |
| (a) <u>Gastro-enteritis</u>   |  |   | <u>4 days</u>                              |
| (b) <u>Possible Intestinal Flu</u>  |  |   |  |
| (c) <u>No doctor or any one in attendance he would not allow one</u>  |  |   |  |
| 2. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |  |
|   |  |   |  |
| 21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)            |  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY  |  | INJURY OCCURRED HOW DID INJURY OCCUR?   |  |
| m. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> . |  |   |  |
| SIGNATURE<br><u>W. Henry Fisher</u>   |  | DATE SIGNED<br><u>2/2-51</u>  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)  |  | NAME OF CEMETERY OR CREMATORY   |  |
| <u>Interment</u>  |  | <u>Oaklawn</u>  |  |
| DATE THEREOF<br><u>Feb 6-1951</u>   |  | LOCATION (City, town, or county) (State)<br><u>Fairfield Conn</u>                                     |  |
| DATE REC'D BY LOCAL REG.<br><u>Feb 4-1951</u>   |  | 24. FUNERAL DIRECTOR<br><u>Barton Bros. Centerville</u>   |  |
| REGISTRAR'S SIGNATURE<br><u>Helen M. Aldridge</u>   |  | ADDRESS<br><u>Centerville Md.</u>   |  |

MARGIN RESERVED FOR BINDING

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LEADER

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